

VA National Center for Patient Safety

First Do No Harm

The Department of Veterans Affairs (VA) National Center for Patient Safety was established in 1999 to lead the VA's patient safety efforts and to develop and nurture a culture of safety throughout the Veterans Health Administration (VHA). Our primary goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

Taking a "Systems Approach"

Our program is based on a systems approach to problem solving that focuses on *prevention*, not *punishment*. We use human factors engineering methods and apply ideas from "high reliability" organizations, such as aviation and nuclear power, to target and eliminate system vulnerabilities. Inadvertent adverse events seldom occur for a single reason or because of one person's actions, but rather from a complex interaction of many components in a healthcare system.

Taking Action

One such systems approach to problem solving resulted in the Ensuring Correct Surgery Directive. Wrong site, wrong patient and/or wrong implant procedures are relatively uncommon adverse events, but often devastating when they occur. The directive offers a straightforward, five-step procedure to identify the correct patient, mark the correct site and ensure the correct procedure or implant.



Getting to the Root Cause of an Inadvertent Adverse Medical Event

We use a multi-disciplinary team approach, known as Root Cause Analysis (RCA), to study adverse medical events and close calls (sometimes called "near misses"). The goal of each RCA is to find out *what happened*, *why it happened*, and *what must be done to prevent it from happening again*. Training programs, cognitive aids, and companion software have been developed by NCPS to support facility RCA teams. Along similar lines, NCPS developed and implemented the Healthcare Failure Modes and Effect AnalysisSM training program and other tools for health care facilities to use in proactive risk assessment and prevention.



Confidential Reporting Systems Make a Huge Difference

We've developed an internal, confidential, non-punitive reporting system. Our Patient Safety Information System (SPOT) can be used to electronically document patient safety information. This information can be analyzed so that corrective actions can be taken and lessons learned can be shared across the system.

Following the implementation of these and other NCPS programs, we saw a 900-fold increase in reporting of close calls, reflecting the level of commitment to the program by VHA leaders and staff.

The innovative external Patient Safety Reporting System (PSRS) functions as a "safety valve" for all VA employees. It was jointly developed by the VHA and the National Aeronautics and Space Administration. PSRS is modeled after NASA's very successful Aviation Safety Reporting System that has been in operation for more than 25 years.

We're a National Team

Our multi-disciplinary team is located in Ann Arbor, Mich., Wash., D.C., and White River Junction, Vt. We offer expertise on an array of patient safety and related health care issues. Patient safety managers in the 162 VA hospitals and patient safety officers in the 21 VA regional headquarters actively participate in the program.



From the Director, Dr. James P. Bagian

Thank you for taking time to learn more about patient safety! It's a critical problem in healthcare. Safety is the foundation upon which quality is built.

In the United States, estimates of the lives lost due to factors related to patient safety exceed that of lives lost due to motor vehicle accidents, breast cancer, or AIDS, as the landmark 1999 Institute of Medicine study, To Err is Human, shows.

Fortunately, interest in improving patient safety is at an all-time high. We're proud that VA addressed the problem early. We've aggressively developed and deployed systems that are in use throughout VA and have been adopted as a benchmark by healthcare organizations throughout the world.

In the last two years alone, NCPS has trained individuals from more than 30 domestic healthcare systems or providers, such as Vanderbilt, the University of Michigan, and Dartmouth. Internationally, we have trained representatives from nine countries, including Denmark and Australia, which have subsequently implemented national programs based on the VA model.

It's important to remember that patient safety is not a destination — it's a never-ending journey. We must remain committed to self-examination that relentlessly and skeptically challenges the way we do things.

The goal of patient safety is not to eliminate all errors. Patient safety programs focused exclusively on eliminating errors will fail. We're human. We'll never eliminate all errors. The real goal is to prevent harm to our patients. We pursue this goal so that we can significantly improve the probability that the desired patient outcome is achieved. How? By taking a systems approach to problem solving.

Historically, we in medicine have relied on people being perfect and equipment never failing. It never worked and, for too long, we were afraid to admit it. It's time to abandon this failed approach that requires personal perfection to make our care systems succeed. It's time to look past the overly simplified answer — that an adverse event is always someone's fault. The real cause is most often a chain of events that has gone unnoticed, leading to a recurring safety problem. It is seldom related to the actions of just one individual.

We at NCPS take a preventive approach to improving patient care by looking for ways to break that link in the chain of events that can cause a recurring problem. We focus on building care systems that are "fault-tolerant," reducing or eliminating the possibility that harm can come to a patient. Such systems are designed to succeed even if individual components fail.

It's been said that experience is the best teacher, but it's also the most expensive. In the case of medicine, mistakes can result in dire consequences to our patients. We believe that only by taking a preventive systems-based approach can we avoid a costly tuition borne of human tragedy.

In closing, I encourage you to learn more about patient safety. I can assure you of this: We at NCPS have an unwavering commitment to assist and encourage all VA healthcare providers in their aggressive pursuit of patient safety initiatives that prevent harm to patients.

James P. Bagian, M.D., P.E.

Director

National Center for Patient Safety

Program and Initiative Highlights

Patient Safety Training and Presentations

We hold training seminars for VA healthcare professionals at locations around the country, and welcome participants from outside the VA when possible. NCPS representatives have traveled around the nation and the world to share our concept of how to develop a culture of safety.

Development of Tool Kits and Cognitive Aids for Frontline Health Care Professionals

We've developed a number of human factors-oriented tool kits that promote patient safety while enhancing the user's awareness of the importance of developing a culture of safety. We've also produced a wide range of cognitive aids to further reduce the risk of causing inadvertent harm to patients.

Business Case for Patient Safety

We're helping our patient safety managers build business cases for patient safety through a better understanding of the importance of developing benefit cost measures. We're also promoting a greater awareness of the impact the lack of patient safety has on resources available for patient care.

High Risk Team Training

We've recruited several facilities to participate in a three-month-long pilot program to evaluate the effectiveness of team training in high risk environments in the VA healthcare system. The concept is grounded in two decades of aviation safety and human factors engineering studies.

Patient Safety Assessment Tool

We're developing a tool that will allow patient safety managers to complete a detailed assessment of the status of their facility's program. The questions relate directly to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements.

Curriculum Development

Realizing that the place to begin learning about patient safety is during early training, we're working with healthcare professionals from VA medical centers and affiliated universities who have volunteered to assist with the development and pilot testing of a patient safety curriculum. The pilot is for residents, medical students, nurses, pharmacists, and other allied healthcare workers.

Medication Safety

In particular, we are concerned with high-alert medications because these drugs are defined as having a higher likelihood of causing injury if misused. Some high-alert medications also have a high volume of use, increasing the likelihood that a patient might suffer inadvertent harm.

Collaboration with Other Organizations

We have developed ongoing working relationships to promote patient safety with organizations such as the Department of Defense, JCAHO, the National Quality Forum and the National Foundation for Patient Safety.

Alerts, Advisories and Other Publications

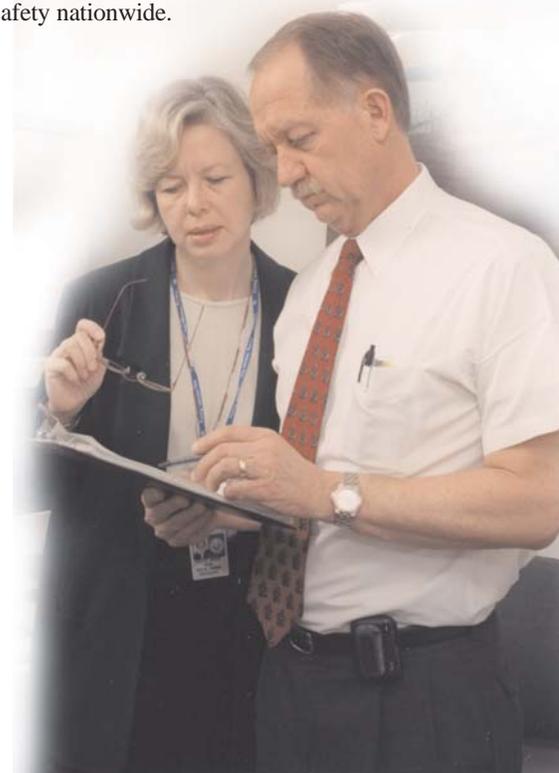
We publish safety alerts or advisories on specific issues relating to equipment, medications and procedures that might cause harm to our patients. We also publish a bimonthly newsletter, *TIPS*, that discusses a wide range of patient safety issues.

Tailored Root Cause Analysis (RCA) Feedback for Facilities and Networks

RCAs submitted to us by RCA teams are reviewed and evaluations are sent back to them to optimize the learning process.

Patient Safety Improvement Corps

NCPS has been designated by the Department of Health and Human Services' Agency for Healthcare Research and Quality to formulate, manage and implement a multifaceted training program for state health officials and their selected hospital partners. It is expected to improve patient safety nationwide.



“To care for him who shall have borne the battle and for his widow and his orphan.”

Abraham Lincoln,
Second Inaugural Address

The Veterans Healthcare System

NCPS is part of the Veterans Healthcare System, the largest integrated healthcare system in the nation, serving the needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

Our healthcare system supports innovation, empowerment, productivity and continuous improvement. Working together, we provide a continuum of high quality healthcare in a convenient, responsive, caring manner—and at a reasonable cost.

Healthcare is perhaps the most visible of all VA benefits and services. From 54 hospitals in 1930, VA's healthcare system has grown to 162 hospitals, with at least one in each of the 48 contiguous states, Puerto Rico and the District of Columbia.

VA operates more than 850 ambulatory care and community-based outpatient clinics, 137 nursing homes, 43 domiciliaries and 73 comprehensive home-care programs. VA healthcare facilities provide a broad spectrum of medical, surgical and rehabilitative care.

More than 4.8 million people received care in VA healthcare facilities in 2003. VA is used annually by approximately 75 percent of all disabled and low-income veterans.

In 2003, VA treated 567,300 patients in VA hospitals and contract hospitals; 55,756 in nursing homes; and 25,314 in residential rehabilitation treatment programs. VA's outpatient clinics registered approximately 49.8 million visits.

VA manages the largest medical education and health professions training program in the United States. VA facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,200 other schools across the country. Each year, about 81,000 health professionals are trained in VA medical centers. More than half of the physicians practicing in the United States have received part of their professional education in the VA healthcare system.

VA's medical system serves as a backup to the Defense Department during national emergencies and as a federal support organization during major disasters.

During the last several years, VA has put its healthcare facilities under 21 networks, which provide more medical services to more veterans and family members than at any time during VA's long history.



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